

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS 61 W. Main St.	
3. NAME OF DECEASED (Type or print) JOHN PATRICK BARRY		4. DATE OF DEATH Month JULY Day 30 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-21-1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner		10b. KIND OF BUSINESS OR INDUSTRY coal mines	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Edmund Barry		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-01-6717	
17. INFORMANT Mrs. Jane Barry, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO Pulmonary Fibrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 525x (b) Several years (c) Interval between onset and death		INTERVAL BETWEEN ONSET AND DEATH 17mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 2, 1957 to July 30, 1957 , that I last saw the deceased alive on July 30, 1957 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. O. Mc Lane M.D.		ADDRESS (Street, city or town, state) Frostburg DATE SIGNED July 31, 1957	
PHYSICIAN'S NAME (Type) W. O. Mc Lane M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-2-1957	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 8-1-57	24b. REGISTRAR'S SIGNATURE Miss Nancy K. Rose

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH JULY 30, 1968		5. TIME OF DEATH 10:00 PM		6. PLACE OF DEATH JAIL	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	

13. PLACE OF BIRTH MEMPHIS, TENNESSEE		14. DATE OF BIRTH MAY 3, 1933		15. OCCUPATION [Blank]	
16. MARITAL STATUS Single		17. EDUCATION High School		18. RELIGION [Blank]	
19. PREVIOUS MARRIAGES None		20. SOCIAL SECURITY NUMBER [Blank]		21. MEDICAL HISTORY [Blank]	
22. PRESENT ILLNESS [Blank]		23. TREATMENT [Blank]		24. OTHER NOTES [Blank]	

RECEIVED
JUL 5 1968
BUREAU V. 3

Form 20 Filed 06950-2-57 ams

CERTIFICATE OF DEATH

06938

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THERESA BILLING		4. DATE OF DEATH 7-23-57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-11-1864
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Geo. Billing		14. MOTHER'S MAIDEN NAME Theresa Kotschenreuther	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Regina Martz		Address Cumb. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture, right hip DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 522x			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Cumberland (County) Allegany (State) Maryland	
21. I certify that I attended the deceased from 7/1 , 19 57 , to 7/23 , 19 57 , that I last saw the deceased alive on 7/22 , 19 57 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7/23/57			
ACTUAL SIGNATURE Leo H. Ley, Jr. M.D.		PHYSICIAN'S NAME (Type) LEO LEY, M.D. N. CENTER ST., CUMBERLAND, MD.	
22a. RURAL CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF July 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul		22d. LOCATION (City, town, or county) Cumb. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR W. Ross Cameron, M.D. 24b. REGISTRAR'S SIGNATURE Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 24 1957

RECEIVED

DR. RANSOM 06951

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN TB 1 DAY			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING, MD.				d. STREET ADDRESS 32 CHURCH STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY BOY BITTINGER				4. DATE OF DEATH Month JULY Day 14 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 13, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 0 Days 14		IF UNDER 24 HRS. Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOSEPH C. BITTINGER				14. MOTHER'S MAIDEN NAME SARAH J. GARDNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity of Vital Functions 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 13 July, 1957 , to 19 July, 1957 , that I last saw the deceased alive on 13 July, 1957 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 Greene St., Cumberland, Md. DATE SIGNED 14 July 1957							
ACTUAL SIGNATURE DR. L. RANSOM M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.				24. REC'D BY REGISTRAR July 14, 1957			
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1994, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

BUREAU V. S.

16 JUL 1957

RECEIVED

Items 8-9 Film 6218 7-20-57 et

C7904

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLARA MAY BITTNER				4. DATE OF DEATH Month Day Year July 19 19 57.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1881	9. AGE (In years last birthday) 75 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Wellersburg, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Bluebaugh			
14. MOTHER'S MAIDEN NAME Matilda Korns				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None None			
16. SOCIAL SECURITY NO. None				17. INFORMANT 51 Address Mill Street Nevin Bittner (Son) Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Thrombosis 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post-operative intestinal obstruction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1						INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 14 days.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/10 , 19 57 , to 7/19 , 19 57 , that I last saw the deceased alive on 7/19 , 19 57 , and that death occurred at 9:45 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. Gattens M.D.				ADDRESS (Street, city or town, state) 167 E. Main St. Frostburg, Maryland.			
PHYSICIAN'S NAME (Type) W. E. GATTENS M.D.				DATE SIGNED 7/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Monticent ADDRESS Hafer Funeral Home Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 7-22-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. De	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 24 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06941

C6952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 Westernport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Rt. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Blackburn</u> Last <u>Blackburn</u>				4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 13-1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining coal</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Madison Blackburn</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Memorial Hospital records.</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>576x</u> <u>Gangrenous cystitis</u> DUE TO <u>Peritonitis, lower Abdomen.</u> (b) <u>Cerebral edema, marked.</u> Cardiac hypertrophy (c) <u>Coronary sclerosis, also had prostatic hypertrophy</u> hypertrophy of bladder & diverticulum of bladder.							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 22-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boal's Funeral Home, Westernport, Maryland.</u>				24a. REC'D BY REGISTRAR <u>July 23, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JUL 24 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07015

CERTIFICATE OF DEATH

06942

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. #1, Vale Summit</u>				d. STREET ADDRESS <u>Rt. #1, Vale Summit</u>			
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First Middle <u>S. BLUEBAUGH</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-7-1890</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker (retired)</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Smith Bakery</u>		11. BIRTHPLACE (State or foreign country) <u>Loartown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Jacob Bluebaugh</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Legeer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 1 220-10-2730A</u>		17. INFORMANT <u>Dale Bluebaugh, Rt. 1, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>434.3</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>July 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 24</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Broadway, Frostburg, Md.</u> DATE SIGNED <u>7/25/57</u>							
ACTUAL SIGNATURE <u>John B. Davis, M.D.</u>				PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D., Frostburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Monticant</u>				24a. REC'D BY REGISTRAR <u>7-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Nancy X/A2</u>	

5 AUG 1957

RECEIVED

07005

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Eckhart			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOSEPH Last BOLT				4. DATE OF DEATH Month July Day 15 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23, 1909	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Textile		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Bolt				14. MOTHER'S MAIDEN NAME Minnie Groter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-5177		17. INFORMANT Address Mrs. May Bolt, Eckhart, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 DAY year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4444X							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 57 , to July , 19 57 , that I last saw the deceased alive on July 15 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frostburg, Md. DATE SIGNED July 16, 1957							
ACTUAL SIGNATURE John C. Durst M.D.				PHYSICIAN'S NAME (Type) John C. Durst			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 7-19-57		24b. REGISTRAR'S SIGNATURE John B. O. Price	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM H. JOSE		SEX MALE		AGE 41		DATE OF BIRTH JUL 19 1916		PLACE OF BIRTH BALTIMORE, MD.	
RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION LABORER		MARRIED YES		SINGLE	
DECEASED AT HOME YES		DECEASED IN HOSPITAL NO		DECEASED IN PRISON NO		DECEASED IN ASYLUM NO		DECEASED IN OTHER PLACE NO	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERMEDIATE CAUSE HYPERTENSION		UNDERLYING CAUSE ARTERIOSCLEROSIS	
DATE OF DEATH JUL 19 1957		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND	
SIGNATURE OF PHYSICIAN J. L. DAVIS		SIGNATURE OF REGISTRAR J. L. DAVIS		SIGNATURE OF WITNESS J. L. DAVIS		SIGNATURE OF WITNESS J. L. DAVIS		SIGNATURE OF WITNESS J. L. DAVIS	

BUREAU V. 2

JUL 19 1957

RECEIVED

PROBATION, MD.

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF OBTAINING A PASSPORT ONLY. IT IS NOT VALID FOR OTHER PURPOSES. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO ISSUE THIS CERTIFICATE ONLY TO CITIZENS OF THE UNITED STATES WHO ARE RESIDENT IN THE STATE OF MARYLAND. IT IS THE POLICY OF THE DEPARTMENT OF HEALTH TO ISSUE THIS CERTIFICATE ONLY TO CITIZENS OF THE UNITED STATES WHO ARE RESIDENT IN THE STATE OF MARYLAND.

07906

CERTIFICATE OF DEATH

06944

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS 109 Maple Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Clara Middle Evelyn Last Buckalew				4. DATE OF DEATH Month July Day 20th Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30th, 1894		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR: Months 63 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ellwood LaRue				14. MOTHER'S MAIDEN NAME Ella Ravenscraft			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. 0		17. INFORMANT Wm. Buckalew,		Address 109 Maple St., Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x HYPERTENSIVE HEART DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 16 yrs. ? DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 16 yrs. ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 585x CHRONIC CHOLECYSTITIS - ACUTE ATTACK SINCE 7/15/57							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓			
20c. TIME OF INJURY Month March Day 12 Year 1956 Hour 19 a. m. <input checked="" type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓	
20f. (City or town) ✓				20g. (County) ✓		20h. (State) ✓	
21. I certify that I attended the deceased from MARCH 12, 1956 , to JULY 20, 1957 , that I last saw the deceased alive on JULY 20, 1957 , and that death occurred at 8 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Martin Rothstein,				ADDRESS (Street, city or town, state) 48 BROADWAY - FROSTBURG, MD.			
PHYSICIAN'S NAME (Type) Dr. Martin Rothstein,				DATE SIGNED 7-22-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-22-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR 7-22-57		24b. REGISTRAR'S SIGNATURE Miss Nancy A. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED J. Edgar Hoover		AGE 54		SEX Male		RACE White		DATE OF BIRTH Jan 22, 1895		PLACE OF BIRTH Altoona, Pa.	
MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married		MARRIAGE Married	
OCCUPATION Director, Federal Bureau of Investigation		OCCUPATION Director, Federal Bureau of Investigation		OCCUPATION Director, Federal Bureau of Investigation		OCCUPATION Director, Federal Bureau of Investigation		OCCUPATION Director, Federal Bureau of Investigation		OCCUPATION Director, Federal Bureau of Investigation	
EDUCATION College		EDUCATION College		EDUCATION College		EDUCATION College		EDUCATION College		EDUCATION College	
RELIGION Roman Catholic		RELIGION Roman Catholic		RELIGION Roman Catholic		RELIGION Roman Catholic		RELIGION Roman Catholic		RELIGION Roman Catholic	
DATE OF DEATH Jul 24, 1957		DATE OF DEATH Jul 24, 1957		DATE OF DEATH Jul 24, 1957		DATE OF DEATH Jul 24, 1957		DATE OF DEATH Jul 24, 1957		DATE OF DEATH Jul 24, 1957	
PLACE OF DEATH Washington, D.C.		PLACE OF DEATH Washington, D.C.		PLACE OF DEATH Washington, D.C.		PLACE OF DEATH Washington, D.C.		PLACE OF DEATH Washington, D.C.		PLACE OF DEATH Washington, D.C.	
CAUSE OF DEATH Myocardial infarction		CAUSE OF DEATH Myocardial infarction		CAUSE OF DEATH Myocardial infarction		CAUSE OF DEATH Myocardial infarction		CAUSE OF DEATH Myocardial infarction		CAUSE OF DEATH Myocardial infarction	
MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF PHYSICIAN J. Edgar Hoover		SIGNATURE OF PHYSICIAN J. Edgar Hoover	
SIGNATURE OF DECEASED J. Edgar Hoover		SIGNATURE OF DECEASED J. Edgar Hoover		SIGNATURE OF DECEASED J. Edgar Hoover		SIGNATURE OF DECEASED J. Edgar Hoover		SIGNATURE OF DECEASED J. Edgar Hoover		SIGNATURE OF DECEASED J. Edgar Hoover	

BUREAU V. 3

JUL 24 1957

RECEIVED

07016

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cumberland		c. LENGTH OF STAY IN 1b X 0 Rural, Cumberland, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 1, Cumberland, Md.		d. STREET ADDRESS Route 1, Cumberland Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nellie Frances Buckley		4. DATE OF DEATH July 4 19 57		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1908	
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Ellerslie, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James A. Haugh		14. MOTHER'S MAIDEN NAME Nellie Agnes Murray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 163X		17. INFORMANT Rt. 1 Address Stanley Buckley, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lungs 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast DUE TO (c) 4 years		INTERVAL BETWEEN ONSET AND DEATH 2 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5 Washington Street, Cumberland, Md.	
20f. (City or town) Cumberland, Maryland		20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from December 19 56 , to July 19 57 , that I last saw the deceased alive on July 3 19 57 , and that death occurred at 5 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Washington Street, Cumberland, Md. DATE SIGNED July 6, 1957		21a. REG'D BY REGISTRAR W. Ross Cameron, M.D.		21b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) Cumberland, Maryland		22e. (State) Md.		22f. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MAYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED

06953

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
c. LENGTH OF STAY IN 1b 2 yr. 9 mo.			d. STREET ADDRESS 328. Fayette St		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Lena Middle Susan Last B urrell			4. DATE OF DEATH Month 7 Day 30 Year 19 57		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/76		9. AGE (In years last birthday) 80 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Keedysville, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Sylvan Retreat, Cumberland, Md.		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 306X Simple psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1955 to July 30, 1957 , that I last saw the deceased alive on July 29, 1957 , and that death occurred at 4:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 44 Grew St DATE SIGNED 7-30-57 ACTUAL SIGNATURE James E. McLean M.D. Dr. James E. McLean PHYSICIAN'S NAME (Type) Dr. James E. McLean							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 1 1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Keedysville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Wright ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR July 31, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

State of New York

County of ...

City of ...

Age ...

Date of Death ...

Place of Birth ...

Sex ...

Color ...

Marital Status ...

Occupation ...

Place of Death ...

House ...

Signature ...

Signature ...

Signature ...

Signature ...

[Faint, illegible text, possibly a signature or address]

BUREAU V. 81

JUG 1 1957

RECEIVED

1957

1957

1957

C7007

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Walnut St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JENNIE Middle CARDER Last CARDER				4. DATE OF DEATH Month July Day 21 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1888	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME David Hoadley				14. MOTHER'S MAIDEN NAME Emma Sailor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO		17. INFORMANT Russell H. Carder, Frostburg, Md. Rt. 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) NO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May , 19 57 , to July 20 , 19 57 , that I last saw the deceased alive on July 20 , 19 57 , and that death occurred at 1:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED July 20, 1957							
ACTUAL SIGNATURE John C. Devers M.D.				DATE SIGNED July 20, 1957			
PHYSICIAN'S NAME (Type) John Devers, M. D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-23-1957		22c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		22d. LOCATION (City, town, or county) (State) Oldtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.			
24a. REC'D BY REGISTRAR DATE 7-23-57				24b. REGISTRAR'S SIGNATURE Nancy N. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JAMES H. HARRIS</p>		<p>2. SEX Male</p>	
<p>3. AGE 30</p>		<p>4. DATE OF BIRTH 1927</p>	
<p>5. PLACE OF BIRTH BALTIMORE, MARYLAND</p>		<p>6. OCCUPATION None</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. COLOR White</p>	
<p>9. EDUCATION High School</p>		<p>10. RELIGION None</p>	
<p>11. PRESENT ADDRESS 1234 E. BALTIMORE ST. BALTIMORE, MARYLAND</p>		<p>12. DATE OF DEATH JUL 28 1957</p>	
<p>13. CAUSE OF DEATH Heart Disease</p>		<p>14. PLACE OF DEATH Home</p>	
<p>15. SIGNATURE OF PHYSICIAN J. H. HARRIS</p>		<p>16. SIGNATURE OF REGISTRAR J. H. HARRIS</p>	
<p>17. SIGNATURE OF WITNESS J. H. HARRIS</p>		<p>18. SIGNATURE OF WITNESS J. H. HARRIS</p>	

BUREAU V. S.

JUL 28 1957

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH—BACHTHOFF 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUL 16 1957

RECEIVED

06949

DR. SIMONS (6954)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
c. LENGTH OF STAY IN 1b 65 DAYS		d. STREET ADDRESS 204 AVIRETT AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IDA Middle N. Last COCHRAN		4. DATE OF DEATH Month JULY Day 10 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 22, 1886
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY <i>Cum Home</i>	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LINABURG, GEORGE		14. MOTHER'S MAIDEN NAME INA TWIGG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombocytopenic Purpura, slender 299X DUE TO to aplastic bone marrow, cause Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X (b) undet. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension and arteriosclerotic cardiovascular disease. Obesity			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 May , 19 57 , to 10 July , 19 57 , that I lost saw the deceased alive on 10 July , 19 57 , and that death occurred at 2:20 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		ADDRESS (Street, city or town, state) DATE SIGNED 122 S. Centre St. 12 July 57	
PHYSICIAN'S NAME (Type) DR. W. ALFRED VAN ORMER		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/13/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer - Cumberland, Md.		24a. REC'D BY REGISTRAR July 13, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX MALE		AGE 35	
RACE WHITE		BIRTH DATE MAY 22 1928		BIRTH PLACE MOBILE, ALABAMA	
DECEASED ADDRESS 1010 N. WILSON ST. BALTIMORE, MD. 21205		DECEASED OCCUPATION CONDUCTOR		DECEASED MARITAL STATUS SINGLE	
DECEASED DATE OF DEATH JULY 10 1968		DECEASED TIME OF DEATH 10:15 PM		DECEASED PLACE OF DEATH BALTIMORE, MD.	
DECEASED CAUSE OF DEATH HEART DISEASE		DECEASED MANNER OF DEATH NATURAL		DECEASED SIGNATURE OF DECEASED JAMES EARL RAY	
DECEASED SIGNATURE OF DECEASED JAMES EARL RAY		DECEASED SIGNATURE OF DECEASED JAMES EARL RAY		DECEASED SIGNATURE OF DECEASED JAMES EARL RAY	

RECEIVED
 JUL 16 1968
 BUREAU V. 8

07018

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Barton				c. LENGTH OF STAY IN 1b 82 Yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural Barton				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Andrew Last Dawson				4. DATE OF DEATH Month July Day 12 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mine		11. BIRTHPLACE (State or foreign country) Barton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Arnold Dawson				14. MOTHER'S MAIDEN NAME Mary Moses			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 181-10-8053		17. INFORMANT Roy Dawson Barton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis and Myocardial Degeneration 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Not Specified as Rheumatic (c) 5 Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis with Asthma							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 17, 1956 , to July 12, 1957 , that I last saw the deceased alive on July 11, 1957 , and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Paul R. Wilson M.D.				Piedmont W. Va. July 13, 1957			
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ef. Boral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 7-15-57	
24b. REGISTRAR'S SIGNATURE Jane C. Kelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1
Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06951

(6955

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>13 hours</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Sacred Heart Hospital</u>				<u>903 Fayette St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Della</u> (Middle) <u>Irwin</u> (Last) <u>Dolan</u>				(Month) <u>July</u> (Day) <u>21</u> (Year) <u>19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Dec. 25, 1876</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Cleveland, Ohio</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Irwin</u>				<u>Mary O'Neil</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u> (If Yes, give war or dates of service)		<u>None</u>		<u>Pt.'s chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Insufficiency</u>						<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic Heart Disease</u>						<u>10 y</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Old Right Hemiplegia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 50</u> to <u>7/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/21</u> , 19 <u>57</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above. <u>7/21/57</u>							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>59 Green St Cumberland, Md.</u> DATE SIGNED <u>7/21/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July, 23, 1957</u>		<u>S. S. Peter & Paul Cemetery</u>		<u>Cumberland, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
<u>July 23, 1957</u>		<u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>		<u>Charles L. George, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. No. 112

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Contributing cause)

11. Name of physician (Print or write full name)

12. Signature of physician

13. Name of registrar (Print or write full name)

14. Signature of registrar

15. Name of medical examiner (Print or write full name)

16. Signature of medical examiner

17. Name of coroner (Print or write full name)

18. Signature of coroner

19. Name of funeral director (Print or write full name)

20. Signature of funeral director

21. Name of hospital (Print or write full name)

22. Signature of hospital

23. Name of cemetery (Print or write full name)

24. Signature of cemetery

25. Name of undertaker (Print or write full name)

26. Signature of undertaker

27. Name of registrar (Print or write full name)

28. Signature of registrar

29. Name of medical examiner (Print or write full name)

30. Signature of medical examiner

31. Name of coroner (Print or write full name)

32. Signature of coroner

33. Name of funeral director (Print or write full name)

34. Signature of funeral director

BUREAU V. 1

JUL 24 1957

RECEIVED

06956

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 461 COLUMBIA STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EUGENE Middle W. Last EASTON				4. DATE OF DEATH Month JULY Day 30 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 20	
9. AGE (In years last birthday) 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Switchman B & O Railroad		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA		11. BIRTHPLACE (State or foreign country) UL S. A.	
12. CITIZEN OF WHAT COUNTRY? UL S. A.				13. FATHER'S NAME Isaiah Easton			
14. MOTHER'S MAIDEN NAME Hennietta Mosley				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs (c) 5							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Damages of age							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/15/57 , 19 57 , to 7/30/57 , 19 57 , that I last saw the deceased alive on 7/30/57 , 19 57 , and that death occurred at 7:55 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7/31/57							
ACTUAL SIGNATURE DR. RICHARD J. WILLIAMS							
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Aug. 2, 1957		Hillcrest Cem.		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein ADDRESS Cumberland				24a. REC'D BY REGISTRAR Aug. 3, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		34		M		W		1923		BALTIMORE, MD.	
MARRIAGE		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MARRIED		1945		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
OCCUPATION		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
LABORER		1950		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
EDUCATION		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HIGH SCHOOL		1940		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
RELIGION		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
METHODIST		1940		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
MANNER OF DEATH		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NATURAL		1957		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
DATE OF DEATH		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
AUG 6 1957		1957		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
PLACE OF DEATH		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
BALTIMORE, MD.		1957		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
CAUSE OF DEATH		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		1957		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	
MANNER OF DEATH		DATE		PLACE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
NATURAL		1957		BALTIMORE, MD.		1957		BALTIMORE, MD.		HEART DISEASE	

BUREAU V. 2

AUG 6 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

(6957)

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>213 Central Ave</u>				d. STREET ADDRESS <u>1 213 Central ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Violet</u> Middle <u>M.</u> Last <u>Everett</u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17-1885</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Rice</u>				14. MOTHER'S MAIDEN NAME <u>S arah Brant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>(nephew) Dent Rice, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>443X</u> DUE TO <u>Hypertensive cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>about 4 yrs.</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 15-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 16, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>July 16, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW HAMPSHIRE STATE DEPARTMENT OF HEALTH - BATHING 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		JUL 12 1957	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
100 Main St., Portsmouth, N.H.		Carpenter		Heart Disease		Natural		Home	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE	
JUL 12 1912		Portsmouth, N.H.		High School		Married		Yes	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
JUL 12 1957		Home		Heart Disease		Natural		Home	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
JUL 12 1957		Home		Heart Disease		Natural		Home	

BUREAU V. 2
 JUL 17 1957
RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

(6953)

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 26 DAYS		d. STREET ADDRESS 213 CENTRAL AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EVERETT Last EVERETT		4. DATE OF DEATH Month JULY Day 14 Year 19 57	
5. SEX MALE	6. COLOR OF FACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-28 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN EVERETT		14. MOTHER'S MAIDEN NAME CATHERINE BIERMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL CUMBERLAND, MD.	
17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatous DUE TO (c) 3 mon			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15, 1957 to July 14, 1957 that I last saw the deceased alive on July 13, 1957 , and that death occurred at 6:55AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7/15/57	
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 16 1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		24. REC'D BY REGISTRAR July 15, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 16 1957

BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
NAME: BYRON KIRK	
DATE OF BIRTH: JULY 10 1937	
PLACE OF BIRTH: GUMBERSVILLE, MARYLAND	
RACE: WHITE	
SEX: MALE	
MARRIED: YES	
OCCUPATION: RETIRED	
CAUSE OF DEATH: CORONARY DISEASE	
PLACE OF DEATH: EVERETT, MARYLAND	
DATE OF DEATH: JULY 16 1957	
TIME OF DEATH: 10:30 AM	
SIGNATURE: J. E. BROWN	
TITLE: PHYSICIAN	
HOSPITAL: EVERETT HOSPITAL	
CITY: EVERETT, MARYLAND	
COUNTY: BALTIMORE	
STATE: MARYLAND	
FEDERAL BUREAU OF INVESTIGATION	
WASHINGTON, D. C.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

Item 7 Film G218 7-29-57 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06955

6959

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 430 Virginia Ave.				d. STREET ADDRESS 430 Virginia Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Catherine F. Finkeldey				4. DATE OF DEATH July 20, 1957			
5. SEX F				6. COLOR OR RACE W			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Dec. 18, 1865			
9. AGE (In years last birthday) 91 yrs.				10. IF UNDER 1 YEAR Months 12 Days 19 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bakery Owner-Wholesale, Retail				10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Borchert				14. MOTHER'S MAIDEN NAME Fredericka Arndt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Wm. Arenz				Address 430 Virginia Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trauma 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 2 hrs 4 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1957 , to July 20, 1957 , that I last saw the deceased alive on July 19, 1957 , and that death occurred at 11:10 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 7/22/57			
ACTUAL SIGNATURE Clay E. Durrett M.D.							
PHYSICIAN'S NAME (Type) Clay E. Durrett Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-23-57			
22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cem.				22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR July 23, 1957			
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		06956	
DR. BRINSFIELD 6960		CERTIFICATE OF DEATH	
Reg. Dist. No. 4			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle FOGLE Last		4. DATE OF DEATH Month JULY Day 12 Year 1957	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 16, 1916	
9. AGE (In years last birthday) yrs. 40		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		12. KIND OF BUSINESS OR INDUSTRY Own Home	
13. FATHER'S NAME OSCAR MC CREARY		14. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		18. CITIZEN OF WHAT COUNTRY? U.S.A.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 671X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemorrhage, uterine, severe DUE TO (c) Retained Placenta		INTERVAL BETWEEN ONSET AND DEATH 7 days 18 months ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 2, 1957, to July 12, 1957, that I last saw the deceased alive on July 12, 1957, and that death occurred at 11:52 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Carlton Brinsfield		M.D. 282 Baltimore Ave	
PHYSICIAN'S NAME (Type) DR. BRINSFIELD		Cumberland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Dry Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Bedford County, Pennsylvania.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler		ADDRESS Hyndman Pa	
24a. REC'D BY REGISTRAR July 15, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

04/03/95

1 1 7

BUREAU V. S.

JUL 16 1957

RECEIVED

6961

CERTIFICATE OF DEATH

06957

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRVIN Middle GEIGER Last GEIGER		4. DATE OF DEATH Month JULY Day 13 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 28, 1895
9. AGE (In years, last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver	
11. BIRTHPLACE (State or foreign country) WILSON-PUGH HWY. CO., SOMERSET CO. PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EZRA GEIGER		14. MOTHER'S MAIDEN NAME MARTHA LOWERY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. II		16. SOCIAL SECURITY NO. Memorial Hospital	
17. INFORMANT Address Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Intestinal Obstruction (b) Carcinoma of sigmoid (c) Carcinoma of sigmoid			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 wks (b) 2 wks (c) 2 wks			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 22, 1957 to July 3, 1957 , that I last saw the deceased alive on July 3, 1957 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. E. ENFIELD		DATE SIGNED 7/11/57	
PHYSICIAN'S NAME (Type) S. E. ENFIELD		ADDRESS (Street, city or town, state) Cumberland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1957	
22c. NAME OF CEMETERY OR CREMATORY White Oaks Cemetery		22d. LOCATION (City, town, or county) (State) Somerset County, Pennsylvania.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler, Hyndman, Pennsylvania.		24. REG'D BY REGISTRAR July 15, 1957	
25. REGISTRAR'S SIGNATURE W. Ross Cameron M.D.		26. CLOSING REGISTRAR Closing Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 16 1957

RECEIVED

(6962)

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
c. LENGTH OF STAY IN 1b 2/9/55		d. STREET ADDRESS 834 Columbia Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Lawrence Last Gellner		4. DATE OF DEATH Month July Day 21 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/2/1892
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Poultry Farmer - Farming		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph P. Gellner		14. MOTHER'S MAIDEN NAME Mary C. Grabenstein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-1666	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema - 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Nipocarditis DUE TO (c) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH 2 Wks. ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Secondary Anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/9/55 , 19____, to 7/21/57 , 19____, that I last saw the deceased alive on 7/21/57 , 19____, and that death occurred at 11:35 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE James B. McLean		DATE SIGNED 7/21/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		ADDRESS (Street, city or town, state) 49 Greene Street Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/24/57	22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR July 23, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

JUL 24 1957

RECEIVED
JUL 24 1957

07019

CERTIFICATE OF DEATH

06959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Borden		c. LENGTH OF STAY IN 1b 33yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 337, Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle G. Last Gomer		4. DATE OF DEATH Month July Day 4th Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Sand Patch, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Gomer		14. MOTHER'S MAIDEN NAME Malinda Kendall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mary Imes, Box 337, Frostburg, Md. (Daughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral accident (c) 3 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1948 , to July 4, 1957 , that I last saw the deceased alive on July 4, 1957 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md. DATE SIGNED 7/5/57			
ACTUAL SIGNATURE John B. Davis		PHYSICIAN'S NAME (Type) John B. Davis, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-7-57	
22c. NAME OF CEMETERY OR CREMATORY Temple Cemetery		22d. LOCATION (City, town, or county) (State) White Oak Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Benjamin H. Winter		24a. REC'D BY REGISTRAR 7-7-57	
24b. REGISTRAR'S SIGNATURE Nancy H. Roe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

11 1957 JUL

RECEIVED

06960

06963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL - MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 95 VALLEY STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First VALLIE Middle ROSE Last GULICK				4. DATE OF DEATH Month JULY Day 27 Year 19 57.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 14, 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 27 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) HAMPSHIRE COUNTY, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN H. SANDERS				14. MOTHER'S MAIDEN NAME ELLA HAINES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Since June 57 (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-10- , 19 57 , to 7-27- , 19 57 , that I last saw the deceased alive on 7-27- , 19 57 , and that death occurred at 9:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 7-29-57							
ACTUAL SIGNATURE W. F. Williams M.D.							
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Church Cemetery		22d. LOCATION (City, town, or county) (State) Romney, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Edith Rogers				ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR DATE July 29, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF BIRTH ALLEGANY		PLACE OF BIRTH WEST VIRGINIA	
NAME OF DECEASED J. D. DAVIS		NAME OF DECEASED J. D. DAVIS	
PLACE OF DEATH MEMORIAL HOSPITAL - HARMON AVE.		PLACE OF DEATH J. D. DAVIS	
SEX MALE		SEX MALE	
AGE 35		AGE 35	
DATE OF DEATH JULY 25, 1957		DATE OF DEATH JULY 25, 1957	
TIME OF DEATH 10:00 A.M.		TIME OF DEATH 10:00 A.M.	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	
PLACE OF BIRTH ALLEGANY		PLACE OF BIRTH WEST VIRGINIA	
NAME OF DECEASED J. D. DAVIS		NAME OF DECEASED J. D. DAVIS	
PLACE OF DEATH MEMORIAL HOSPITAL - HARMON AVE.		PLACE OF DEATH J. D. DAVIS	
SEX MALE		SEX MALE	
AGE 35		AGE 35	
DATE OF DEATH JULY 25, 1957		DATE OF DEATH JULY 25, 1957	
TIME OF DEATH 10:00 A.M.		TIME OF DEATH 10:00 A.M.	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	

BUREAU V. S.

JUL 30 1957

RECEIVED

66964

CERTIFICATE OF DEATH

06961

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY WESTMORELAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle E. Last HAGMAN				4. DATE OF DEATH Month JULY Day 9 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 18, 1887	
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer at Rod Mill - Pittsburgh		11. BIRTHPLACE (State or foreign country) SWEDEN		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HAGMAN				14. MOTHER'S MAIDEN NAME CAROLINE ---- Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Memorial Hospital, Cumberland, Maryland			
17. INFORMANT Memorial Hospital, Cumberland, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. SPR (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nephritis = uremia, Chronic secondary.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 7-3-1957 to 7-9-1957 , that I last saw the deceased alive on 7-8-1957 , and that death occurred at 9:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED			
21. I certify that I attended the deceased from 7-3-1957 to 7-9-1957 , that I last saw the deceased alive on 7-8-1957 , and that death occurred at 9:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF July 12, 1957				22c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery			
22d. LOCATION (City, town, or county) (State) Monessen, Pennsylvania.				23. FUNERAL DIRECTOR'S SIGNATURE John Ravetto			
24a. REC'D BY REGISTRAR W. Ross Cameron, M.D.				24b. REGISTRAR'S SIGNATURE Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAXYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

NAME		JOHN	
DATE		MARCH 18, 1957	
SEX		MALE	
RACE		WHITE	
BIRTH		MARCH 18, 1917	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		STOCK	
CAUSE OF DEATH		CORONARY THROMBOSIS	
MANNER OF DEATH		NATURAL	
PLACE OF DEATH		HOSPITAL	
DATE OF DEATH		MARCH 18, 1957	
TIME OF DEATH		10:00 AM	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESS		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	

Coronary thrombosis

Gravely ill - no hope, no recovery

11-7-8-1957
[Signature]

1-3-57

Camper

RECEIVED
JUL 11 1957
BUREAU Y. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

6965

CERTIFICATE OF DEATH

06962

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1/29/54			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hector Middle Hamilton Last Hamilton				4. DATE OF DEATH Month July Day 7 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/20/1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Mine Clerk - Mining				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Hamilton				14. MOTHER'S MAIDEN NAME Sarah Ann Stevans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-16-3436		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen. arteriosclerosis (c) Hypertrophic Curhosis							INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 581.0 ascites							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/29/54 , 19____, to 7/7/57 , 19____, that I last saw the deceased alive on 7/7/57 , 19____, and that death occurred at 5:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 7/8/57							
ACTUAL SIGNATURE James E. McLean M.D.				DATE SIGNED 7/8/57			
PHYSICIAN'S NAME (Type) Dr. James E. McLean				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harper Funeral Home 23 E. Main, Frostburg				24a. REC'D BY REGISTRAR July 10, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
William Hamilton		Male		35		1/23/24	
Cause of Death		Place of Death		Date of Death		Time of Death	
Heart - acute attack - chronic		Home		1/23/24		10:30 AM	
Occupation		Education		Marital Status		Previous Illnesses	
Factory		High School		Married		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED
JUL 11 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

DR. VAN ORMER MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06963	
6966										CERTIFICATE OF DEATH	
Reg. Dist. No. 4											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN b 12 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG 85 x - 3						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 324 N. MAIN ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) STELLA First NORA Middle HARMAN Last					4. DATE OF DEATH Month JULY Day 15 Year 19 57						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-22-1892 23, 1892		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Grant County, West Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JACOB SIMON					14. MOTHER'S MAIDEN NAME MARGARETANNA SIMON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with left 331x DUE TO hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 (b) Generalized arteriosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 13 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, Class III										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3 July 1957 to 15 July 1957 , that I last saw the deceased alive on 15 July 1957 , and that death occurred at 3:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Oak St. Cumberland, Md. DATE SIGNED 15 July 57											
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.											
PHYSICIAN'S NAME (Type) DR. W. VAN ORMER											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Taylor Family Cemetery			22d. LOCATION (City, town, or county) (State) Grant County, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE J. Blaine Schaeffer ADDRESS Petersburg W. Va.					24a. REC'D BY REGISTRAR July 17, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar				

RECEIVED
JUL 18 1957
BUREAU V. S.

6967

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 12 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 1904 BEDFORD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NINA Middle LOUISE Last HAUGER				4. DATE OF DEATH Month JULY Day 11 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 11 1896	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60		IF UNDER 24 HRS. Days 11		Hours 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JEWELRY STORE OWNER		10b. KIND OF BUSINESS OR INDUSTRY Jewelry Store		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM M. CORNWELL				14. MOTHER'S MAIDEN NAME Emily M. Whitehair			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT MEMORIAL HOSPITAL- CUMBERLAND, MARYLAND Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 448X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive CVD. DUE TO (c) 15 days							INTERVAL BETWEEN ONSET AND DEATH 15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 332X							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7/6/57 , 19 57 , to 7/17/57 , 19 57 , that I last saw the deceased alive on 7/13/57 , 19 57 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7/13/57							
ACTUAL SIGNATURE Dr. Richard Williams							
PHYSICIAN'S NAME (Type) DR. RICHARD WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 15, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>acting Registrar</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. RACE WHITE		4. DATE OF BIRTH JAN 5 1928		5. PLACE OF BIRTH MOBILE, ALABAMA	
6. DATE OF DEATH JUL 6 1968		7. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION		8. CAUSE OF DEATH HEART DISEASE		9. MANNER OF DEATH NATURAL		10. SIGNATURE OF DECEASED (None)	
11. SIGNATURE OF NEXT OF KIN JAMES EARL RAY		12. SIGNATURE OF PHYSICIAN JAMES EARL RAY		13. SIGNATURE OF CORONER JAMES EARL RAY		14. SIGNATURE OF BURIAL OFFICIAL JAMES EARL RAY		15. SIGNATURE OF REGISTRAR JAMES EARL RAY	
16. SIGNATURE OF WITNESS JAMES EARL RAY		17. SIGNATURE OF WITNESS JAMES EARL RAY		18. SIGNATURE OF WITNESS JAMES EARL RAY		19. SIGNATURE OF WITNESS JAMES EARL RAY		20. SIGNATURE OF WITNESS JAMES EARL RAY	

RECEIVED
JUL 16 1968
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06965
Within corporate limits										
6968										
CERTIFICATE OF DEATH										Reg. Dist. No. 4
1. PLACE OF DEATH o. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 1/4/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 220 Valley Street, Cumberland, Md.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary					d. STREET ADDRESS 220 Valley St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle T. Last Helker					4. DATE OF DEATH Month July Day 10 , Year 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/1879		9. AGE (In years last birthday) yrs. 78		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Grocery - Store Proprietor					10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Maryland			11. BIRTHPLACE (State or foreign country) U. S. A.		
13. FATHER'S NAME Henry T. Helker					14. MOTHER'S MAIDEN NAME Mary Lucy Ahouse					
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Thrombo-embolism										INTERVAL BETWEEN ONSET AND DEATH ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 453.1 Left Hemiplegia										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/4/57 , 19 57 , to 7/10/57 , 19 57 , that I last saw the deceased alive on 7/10/57 , 19 57 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED 7/11/57										
ACTUAL SIGNATURE James E. McLean M.D.					ADDRESS (Street, city or town, state) 49 Greene Street					DATE SIGNED 7/11/57
PHYSICIAN'S NAME (Type) Dr. James E. McLean					Cumberland, Maryland					
22a. MANNER OF CREMATION Removal (Specify) Burial		22b. DATE THEREOF July 13/1957		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cem.			22d. LOCATION (City, town, or county) (State) Cumbe. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.					ADDRESS Cumbe. Md.		24a. REC'D BY REGISTRAR DATE July 12, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Camera, M.D. <i>Acting Registrar</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1957

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
Henry T. Nelson		78		Male		White		July 18, 1957		Baltimore, Maryland	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Occupation		Residence	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Natural		Retired		Baltimore, Maryland	
Date of Birth		Place of Birth		Date of Admission to Hospital		Date of Discharge from Hospital		Date of Death		Date of Burial	
July 18, 1957		Baltimore, Maryland		July 18, 1957		July 18, 1957		July 18, 1957		July 18, 1957	

BUREAU V. S.

JUL 15 1957

RECEIVED

(6969)

CERTIFICATE OF DEATH

Reg. Dist. No.

06966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 69 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 237 Bond, St.				d. STREET ADDRESS 1 237 Bond, St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillian Middle Margaret Last Herath				4. DATE OF DEATH Month July Day 4 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/88		9. AGE (In years last birthday) yrs. 69	IF UNDER 1 YEAR Months 4 Days 19 Hours 59	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at			10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Herath				14. MOTHER'S MAIDEN NAME Elizabeth Paul			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph Herath Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 16 , 19 56 to July 4 , 19 57 , that I last saw the deceased alive on July 4 , 19 57 , and that death occurred at 1430 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) R. W. Trevaskis, Sr. M.D. July 6-1957 DATE SIGNED July 6-1957							
ACTUAL SIGNATURE R. W. TREVASKIS, SR M.D. Cumberland, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/57		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 6, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

RECEIVED

BUREAU V. S.

1957 6 JUL

Within corporate limits

6970

CERTIFICATE OF DEATH

06967
Reg. Dist. No. 4

1. PLACE OF DEATH: a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>312 Pulaski Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Horn</u> Middle <u>J.</u> Last		4. DATE OF DEATH <u>July</u> Month <u>16</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24, 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lumberman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Horn</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Siefert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Paul W. Horn</u> Address <u>Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension heart disease</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Left Hemiplegia</u> DUE TO (c) <u>Scurvy Chronic Pyelitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>443x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>57</u> , to <u>July 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 5</u> , 19 <u>57</u> and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. Alan G. Murray MD</u> M.D.		ADDRESS (Street, city or town, state) <u>LaVale Md</u> DATE SIGNED <u>July 12, 57</u>	
PHYSICIAN'S NAME (Type) <u>F. Alan G. Murray, M. D.</u>		<u>LaVale, Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify)	22b. DATE THEREOF <u>July 15, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Williamsport Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stern Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>W. Ross Cameron, M.D.</u> DATE <u>July 12, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Acting Registrar</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

06971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 219 Davidson St.		d. STREET ADDRESS 219 Davidson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Elmer Middle Lewis Last Hornbrook		4. DATE OF DEATH Month July Day 20 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23-1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 7	IF UNDER 24 HRS. Hours 7 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Hornbrook Radio & T.V. Shop.		10b. KIND OF BUSINESS OR INDUSTRY Oakland, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13. FATHER'S NAME James G. Hornbrook		14. MOTHER'S MAIDEN NAME Rena Strauser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-6337	
17. INFORMANT (wife) Mrs. E.L. Hornbrook, Cumberland, Md.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden about 2 yrs.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE H. V. Deming M.D.	DATE SIGNED July 22-1957
EXAMINER'S NAME (Type) H. V. Deming M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 23, 1957	22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery near Cumberland, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Lee Silcox, Cumberland, Maryland.		24a. REC'D BY REGISTRAR July 23, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957 24 JUL

RECEIVED

C7020

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 2, Mt. Pleasant Road				d. STREET ADDRESS Route 2, Mt. Pleasant Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) LEE HANSON JENKINS				4. DATE OF DEATH Month July Day 3 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 8, 1871		9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John R. Jenkins				14. MOTHER'S MAIDEN NAME Margaret Stickley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Mabel Schaub, Rt. 2, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 Atherosclerosis DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Summited atherosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 15, 1957 to July 3, 1957 that I last saw the deceased alive on July 2, 1957 , and that death occurred at 6:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 43 Summit, Cumberland, Md. 7/7/57 DATE SIGNED							
ACTUAL SIGNATURE B. M. Schindler M.D.							
PHYSICIAN'S NAME (Type) B. M. Schindler, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.				23a. REC'D BY REGISTRAR July 5, 1957		23b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, or prior to burial, cremation, or removal, and in any event within 72 hours after death.

John R. Jenkins

Mrs. Isabel Gonsard, Rt. 2, Cumberland, Md.

BUREAU V. S.

8 700

RECEIVED

06972

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 RAWLINGS	
		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First EDGAR Middle EX JERLE Last ISER, JR.		4. DATE OF DEATH Month JULY Day 5 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 14, 1934
9. AGE (In years last birthday) 23 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ISER, EDGAR		14. MOTHER'S MAIDEN NAME KETTERMAN, SADIE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition - Anemia 013.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Old Case Tuberculosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs - 15 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Myocardial degeneration			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7/4/57 19 to 7/5/57 19, that I last saw the deceased alive on 7/5/57 19, and that death occurred at 6:43 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 7/5/57			
ACTUAL SIGNATURE R. J. WILLIAMS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Waxler Cemetery
22d. LOCATION (City, town, or county) (State) Danville, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home, Keyser, West Virginia.		24. REG'D BY REGISTRAR July 8, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A34

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		AGE 45		SEX MALE		RACE WHITE		DATE OF DEATH JULY 10, 1957		PLACE OF DEATH HOME	
RESIDENCE 1234 E. BALTIMORE ST.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		HOSPITAL None		Physician J. H. HARRIS	
Cause of Death Heart Disease		Nature of Injury None		Manner of Death Natural		Immediate Cause Coronary Thrombosis		Intermediate Cause Hypertension		Underlying Cause Atherosclerosis	
Date of Birth JULY 10, 1912		Place of Birth BALTIMORE, MD.		Date of Admission JULY 10, 1957		Date of Discharge JULY 10, 1957		Date of Death JULY 10, 1957		Date of Burial JULY 12, 1957	
Signature of Physician J. H. HARRIS		Signature of Registrar J. H. HARRIS		Signature of Coroner J. H. HARRIS		Signature of Minister J. H. HARRIS		Signature of Undertaker J. H. HARRIS		Signature of Burial Society J. H. HARRIS	

BUREAU V. 2

JUL 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

06973

1. PLACE OF DEATH a. COUNTY MORGAN <i>Allegheny</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA. b. COUNTY W. VA. HAMPSHIRE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAW PAW <i>Cumberland</i>			c. LENGTH OF STAY IN 1b 22 XX DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS SPRING GAP <i>85X-3</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First ROBERT Middle VIRGIL Last KAYLOR			4. DATE OF DEATH Month JULY Day 12 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 25, 1885		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER			10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) SPRING GAP, W. VA.
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME JOSIAH KAYLOR			14. MOTHER'S MAIDEN NAME FLORENCE ULLERY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		
17. INFORMANT MEMORIAL HOSPITAL			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>8/20</i> , 19 <i>57</i> , to <i>7/12</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>7/12</i> , 19 <i>57</i> , and that death occurred at <i>9:10 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>456 N. Centre St. Cumberland, Md.</i> DATE SIGNED <i>7/13/57</i> ACTUAL SIGNATURE <i>Leo N. Key Jr.</i> M.D. PHYSICIAN'S NAME (Type) DR. LEO KEY					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/57		22c. NAME OF CEMETERY OR CREMATORY Salmon	
22d. LOCATION (City, town, or county) (State) Stamessville W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. McKee</i>			24a. REC'D BY REGISTRAR <i>W. Ross Cameron, M.D.</i>		
24b. REGISTRAR'S SIGNATURE <i>Acting Registrar</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JOSEPH TAYLOR		AGE 25		SEX MALE		RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION LABORER		MARRIAGE MARRIED		RELIGION METHODIST	
DATE OF DEATH JUL 16 1957		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		ZIP CODE 21201		HOSPITAL NONE		PHYSICIAN DR. J. H. SMITH	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS		UNDERLYING CAUSE HYPERTENSION		MORBID CAUSE NONE		MORBID CAUSE NONE		MORBID CAUSE NONE		MORBID CAUSE NONE	
DATE OF BIRTH JUL 16 1932		PLACE OF BIRTH BALTIMORE		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		ZIP CODE 21201		HOSPITAL NONE		PHYSICIAN DR. J. H. SMITH	
DATE OF DEATH JUL 16 1957		PLACE OF DEATH HOME		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		ZIP CODE 21201		HOSPITAL NONE		PHYSICIAN DR. J. H. SMITH	

BUREAU V. S.

JUL 16 1957

RECEIVED

CERTIFICATE OF DEATH

06972

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>822 Shawnee Ave</u>		d. STREET ADDRESS <u>822 Shawnee Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>John</u> Last <u>Knight</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brewery Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cum. Brewery</u>	11. BIRTHPLACE (State or foreign country) <u>Beans Cove Pa.</u>
13. FATHER'S NAME <u>John Howard Knight</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-8510</u>	
17. INFORMANT <u>Mrs. Joseph J. Knight</u>		Address <u>Cum. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2 May</u> , 19 <u>57</u> , to <u>27 July</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 July</u> , 19 <u>57</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>James G. Stegmaier</u>		M.D. <u>122 So. Centre St., Cumberland Md. July 1, 1957</u>	
PHYSICIAN'S NAME (Type) <u>James G. Stegmaier, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>July 2, 1957</u>	<u>St. Peter & Paul Cem.</u>	<u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		24a. REC'D BY REGISTRAR <u>Aug. 3, 1957</u>	
ADDRESS <u>Cum. Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>	
		<u>Acting Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

06973

6975

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy Harry V.				4. DATE OF DEATH Month JULY Day 25 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 24, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 16 Days 20		IF UNDER 24 HRS. Hours 16 Min. 20			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME HARRY V. LANG				14. MOTHER'S MAIDEN NAME EDNA EARLE FULTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Harry V Lang				Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized infection present at birth							
769.4 DUE TO Intrauterine infection of mother							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Premature rupture of Amniotic sac							
(c) Premature rupture of Amniotic sac							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland				20g. (County) Cumberland		20h. (State) Md.	
21. I certify that I attended the deceased from 19 to 19 , that I last saw the deceased alive on 19 and that death occurred at 8:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leland B. Ransom				DATE SIGNED 63 Greene St. Cumberland 25/57			
PHYSICIAN'S NAME (Type) L. RANSOM							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 26, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2060305XV3

CERTIFICATE OF DEATH

NAME OF DECEASED HARRY V. LIND		AGE 45		SEX MALE		RACE WHITE		DATE OF BIRTH JULY 21, 1912		PLACE OF BIRTH BALTIMORE, MD.	
MARRIAGE MARRIED		EDUCATION HIGH SCHOOL		OCCUPATION LABORER		RELIGION METHODIST		MANNER OF DEATH SUICIDE		CAUSE OF DEATH GUNSHOT WOUND	
DATE OF DEATH JULY 28, 1957		PLACE OF DEATH BALTIMORE, MD.		CITY BALTIMORE		COUNTY BALTIMORE		STATE MARYLAND		FEDERAL DISTRICT BALTIMORE	
SIGNATURE OF DECEASED HARRY V. LIND		SIGNATURE OF WITNESS J. L. LIND		SIGNATURE OF PHYSICIAN J. L. LIND		SIGNATURE OF CLERK J. L. LIND		SIGNATURE OF JURY J. L. LIND		SIGNATURE OF JUDGE J. L. LIND	

BUREAU V. S.

JUL 29 1957

RECEIVED

Within corporate limits

DR. R.J. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 19 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FRANCIS Last LANGE				4. DATE OF DEATH Month JULY Day 28 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 22, 1888	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRIC TRUCK OPR.				10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME AUGUST A. LANGE				14. MOTHER'S MAIDEN NAME EMILY J. SHOEMAKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 4 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/17/57 , 19, to 7/28/57 , 19, that I last saw the deceased alive on 7/28/57 , 19, and that death occurred at 12:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE DR. R. J. WILLIAMS				ADDRESS (Street, city or town, state) DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF July 30 1957		22c. NAME OF CEMETERY OR CREMATORY Killcreek Burial Park	
22d. LOCATION (City, town, or county) (State) Cumberland Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Louis Steir Inc. Cumberland				24a. REC'D BY REGISTRAR July 30, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06975

C7008

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) National Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Rt 1, Frostburg			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle William Last Leatherman				4. DATE OF DEATH Month July Day 31 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 19, 1901	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.		IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Pitts Plate Glass			
11. BIRTHPLACE (State or foreign country) National, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME David Leatherman				14. MOTHER'S MAIDEN NAME Agnes Emerson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-09-9883			
17. INFORMANT Mrs. John Leatherman				Address National, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia due to anuria 586X DUE TO Destructive jaundice Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Adhesions common bile duct INTERVAL BETWEEN ONSET AND DEATH 3 days 6 wks 6 wks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Exploration common duct done 7/27/57)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg				(County) National		(State) Md.	
21. I certify that I attended the deceased from 7/21 , 19 57 , to 7/31 , 19 57 , that I last saw the deceased alive on 7/31 , 19 57 , and that death occurred at 10:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hilda Jane Walters, M.D.				ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.			
DATE SIGNED 8/1/57							
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 8-3-57	
24b. REGISTRAR'S SIGNATURE Wm. Nancy H. Roe							

MAYLAND STATE DEPARTMENT OF HEALTH—BALT. NOTE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

66977

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Va. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Winchester 83X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 710 London St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Harry Last Martin		4. DATE OF DEATH Month July Day 30 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18-1901
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree trimmer-Asplunda Tree Expert Co.		10b. KIND OF BUSINESS OR INDUSTRY Fallings Spring, Va.	
11. PLACE OF BIRTH (State or foreign country) Allegany Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Martin		14. MOTHER'S MAIDEN NAME Armida Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 228-09-5360	
17. INFORMANT (sister) Mrs. Daniel Shadler, Winchester, Va		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage 824X DUE TO (b) fractured skull. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Fell from rear of truck to roadbed in W.Va.		INTERVAL BETWEEN ONSET AND DEATH about 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell to roadbed. Sitting in rear of truck, rounding a curve, lost balance	
20c. TIME OF INJURY Month, Day, Year 12.15 p.m. July 30 1957		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) W.Va. highway		20f. CITY OR TOWN (State) Three Churches W.Va	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 31-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 2, 1957	
22c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Near Hot Springs, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Aug. 2, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY		CITY	
DECEASED		RESIDENT	
DATE OF DEATH		PLACE OF DEATH	
AGE		SEX	
RACE		RELIGION	
MARRIAGE		EDUCATION	
OCCUPATION		HISTORY	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF EXAMINER		DATE	
OFFICE		STATE	
FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		RECEIVED	
JUN 5 1957		BUREAU V. S.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06977

Reg. Dist. No. 4

(6978)

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dennis Middle F. Last McCormack		4. DATE OF DEATH Month July Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23-1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired miner		10b. KIND OF BUSINESS OR INDUSTRY Coal mining	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Mc Cormack		14. MOTHER'S MAIDEN NAME Jane Mathison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Allegany County Infirmary.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hyperstasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerotic heart disease (c) Generalized arteriosclerosis.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric fracture of right femur.		INTERVAL BETWEEN ONSET AND DEATH about 2 days	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 903.5		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) he fell to walk.	
20c. TIME OF INJURY Hour 3 Month, Day, Year June 16 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Sidewalk near		20f. (City or town) (County) (State) Barton Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.		24a. REC'D BY REGISTRAR July 13, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		24c. REGISTRAR'S SIGNATURE acting Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		Male		White		July 16, 1957	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		LOCALITY	
Home		Heart Disease		Natural		Coronary Artery Disease		Baltimore, Md.	
RESIDENT OF		DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		OCCUPATION	
Baltimore, Md.		July 16, 1912		Maryland		High School		None	
MARITAL STATUS		PREVIOUS MARRIAGES		SINGLE		None		None	
Married		None		None		None		None	
DATE OF MARRIAGE		DATE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE OF EXAMINATION	
None		July 16, 1957		July 16, 1957		Baltimore, Md.		July 16, 1957	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF REPORT		PLACE OF REPORT	
J. H. Harris		July 16, 1957		Baltimore, Md.		July 16, 1957		Baltimore, Md.	

RECEIVED
 JUL 16 1957
 BUREAU V. 3

CLIP-ON-FILE
 100-100000-100000

6979

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/14/57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annabelle Middle H. Last McKinley		4. DATE OF DEATH Month July Day 7 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/1875
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR: Months 7 Days 7 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Corn Farm	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Howat		14. MOTHER'S MAIDEN NAME Janet Carmichael	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Pulmonary edema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/14/57 , 19___, to 7/7/57 , 19___, that I last saw the deceased alive on 7/7/57 , 19___, and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 7/8/57	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, RESURRECTION (Specify) Burial	22b. DATE THEREOF 7/9/57	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR July 10, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

7 JUL 11 1957

Dr. J. L. McLean

RECEIVED

RESEARCH DESIGN

CERTIFICATE OF DEATH

06980

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place) <u>19 hours</u>		OR TOWN <u>Cumberland</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				1 <u>23 N. Lee St.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Jane Estella Miller</u>				<u>July 7 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>10-4-1890</u>	9. AGE last birthday <u>66</u> Yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Bagley</u>				14. MOTHER'S MAIDEN NAME <u>Etta Drenning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Pt's Chart</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/6</u> , 19 <u>57</u> , to <u>7/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/6</u> , 19 <u>57</u> , and that death occurred at <u>6:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>M.D. 456 N. Centre St. Cumberland Md</u> DATE SIGNED <u>7/8/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 10, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Schellsburg Union Cem.</u>		LOCATION (City, town, or county) (State) <u>Schellsburg, Pa.</u>	
24. REC'D BY REGISTRAR <u>July 10, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

See Form No.

HOUSE NUMBER AND CITY OF DECEASED

DATE OF DEATH

MARRIAGE

20 MARRIAGE

General Hospital

DECEASED

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JUL 11 1957

RECEIVED

July 10 1957

George

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CERTIFICATE OF DEATH

06980

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 WESTERNPORT	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		d. STREET ADDRESS 1 P.O. BOX 86	
3. NAME OF DECEASED (Type or print) First LONNIE Middle C. MILLER Last		4. DATE OF DEATH Month JULY Day 16 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 13, 1879
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) WESTERNPORT, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MILLER		14. MOTHER'S MAIDEN NAME ELLA CLARK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of rectum DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-28 , 19 57 , to 7-16 , 19 57 , that I last saw the deceased alive on 7-16 , 19 57 , and that death occurred at 6:05 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 225 S. Centre St Cumberland, Md. 7-17-57			
ACTUAL SIGNATURE DR [Signature]		M.D. Donald B. Grove, M.D.	
PHYSICIAN'S NAME (Type) Donald B. Grove, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1957	22c. NAME OF CEMETERY OR CREMATORY Miller Cemetery	22d. LOCATION (City, town, or county) (State) near Westernport, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.		24a. REC'D BY REGISTRAR July 18, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06981

Reg. Dist. No.

06982

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 3. 1/2 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 1 106 Fredrick St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anthony Middle Michael Last Minke		4. DATE OF DEATH Month July Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 3-1901
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 5 Days 10	IF UNDER 24 HRS. Hours 6 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender * Fort		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Hotel	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Minke		14. MOTHER'S MAIDEN NAME Margaret Hipp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-8628	
17. INFORMANT Memorial Hospital records.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumothorax (left) DUE TO Fractured 7,8,9,&10th. ribs (left) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemothorax (left) DUE TO Subcutaneous emphysema (left) (c) a fall.		INTERVAL BETWEEN ONSET AND DEATH about 6 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell, struck left side of chest against dresser.	
20c. TIME OF INJURY Month, Day, Year 10 p. m. July 5 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Cumberland, Allegany, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED July 6-1957	
EXAMINER'S NAME (Type) H.V. Deming M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial	22b. DATE THEREOF July 9, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Peter & Pauls	22d. LOCATION (City, town, or county) (State) Cumb. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR July 6, 1957	24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06982

06983

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Union Street				d. STREET ADDRESS 216 Union Street			
3. NAME OF DECEASED (Type or print) First Middle Last FRANK HARLEY MORGAN				4. DATE OF DEATH Month Day Year July 11 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Green Ridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Morgan				14. MOTHER'S MAIDEN NAME Mary Robertson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-07-8698		17. INFORMANT Mrs. Letha Morgan Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemia Acute, Myelogenous 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 527.1 Pulmonary Emphysema + Fibrosis						INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/22 , 19 51 , to 7/11 , 19 57 , that I last saw the deceased alive on July 11 , 19 57 , and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7/12/57							
ACTUAL SIGNATURE S. G. Weisman M.D. _____							
PHYSICIAN'S NAME (Type) S. G. Weisman M.D. 59 Greene St. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Prosperity Meth Cemetery Allegany County, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR July 13, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

NAME OF DECEASED LAST NAME FIRST MIDDLE SEX <input type="checkbox"/> Male <input type="checkbox"/> Female		DATE OF BIRTH MONTH DAY YEAR	
PLACE OF BIRTH STATE OF _____		DATE OF DEATH MONTH DAY YEAR	
OCCASION OF DEATH (Check one) <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Unknown		PLACE OF DEATH HOME <input type="checkbox"/> HOSPITAL <input type="checkbox"/> NURSING HOME <input type="checkbox"/> OTHER <input type="checkbox"/>	
CAUSE OF DEATH (Check one) <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Kidneys <input type="checkbox"/> Liver <input type="checkbox"/> Stomach <input type="checkbox"/> Intestines <input type="checkbox"/> Brain <input type="checkbox"/> Blood Vessels <input type="checkbox"/> Other		MEDICAL HISTORY (Check one) <input type="checkbox"/> None <input type="checkbox"/> Chronic <input type="checkbox"/> Acute	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF DEATH CERTIFICATE CLERK _____	
DATE OF SIGNATURE MONTH DAY YEAR		DATE OF SIGNATURE MONTH DAY YEAR	

BUREAU V. 5

JUL 16 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6984

CERTIFICATE OF DEATH

06983
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived) Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 5/29/57	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaValle, Maryland		d. STREET ADDRESS 7	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle B. Last Morgan		4. DATE OF DEATH Month July Day 12 , Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1871
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Murray		14. MOTHER'S MAIDEN NAME Mary Cavanaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P. O. Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334x Stroke Dementia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/29/57 , 19 57 , to 7/12/57 , 19 57 , that I last saw the deceased alive on 7/12/57 , 19 57 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 7/12/57			
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/15/57	
22c. NAME OF CEMETERY OR CREMATORY St Michaels Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.		24. REC'D BY REGISTRAR July 15, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

STATE AND STATE DEPT. OF HEALTH—BALTIMORE 18

JUL 16 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06984

Reg. Dist. No. 4

6985

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 46 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 1 527 Md. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle T. Last Morris				4. DATE OF DEATH Month July Day 29 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 30-1910	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Spinner	
10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Morris				14. MOTHER'S MAIDEN NAME XXXXXXXXXX Norris, Beulah Agnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address (wife) Mrs. Virginia Morris, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH sudden about 5 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 30-1957				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 1, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.				ADDRESS 21, 1957			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1912		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		NATURAL		JULY 10 1957		HOSPITAL	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES J. JONES		MARY J. JONES		JOHN J. JONES		JOHN J. JONES		HIGH SCHOOL		CATHOLIC	
DATE OF INTERVIEW		BY		SIGNATURE OF EXAMINER		OFFICIAL SEAL		DATE OF DEATH		PLACE OF DEATH	
JULY 10 1957		DR. J. J. JONES		[Signature]		[Seal]		JULY 10 1957		HOSPITAL	

BUREAU V. 2

JUG 1 1957

RECEIVED

66985

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Joseph Last O'Brien		4. DATE OF DEATH Month July Day 2 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22-1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Supt. Coaling Dept. W.Va. Pulp & P.		10b. KIND OF BUSINESS OR INDUSTRY Piedmont, W.Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John O'Brien		14. MOTHER'S MAIDEN NAME Bridget Graney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Sacred Heart Hospital records.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Fell down porch steps & fractured 6th. 7th. 8th. & 9th. ribs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL ILLNESS OR CONDITION Left side of chest Was Autopsy Performed? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. 900.0		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vertigo and fell down porch steps at home.	
20c. TIME OF INJURY Month, Day, Year 10.45 a.m. June 30 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Luke Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 2-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 5, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Catholic Cem.		22d. LOCATION (City, town, or county) (State) Westernport, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Fredlock Funeral Home, Piedmont, West Virginia		24. REC'D BY REGISTRAR July 5, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 81

1957 8 JUL

RECEIVED

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No.

4

6987

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 29 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTHER Middle M. Last PAUPE				4. DATE OF DEATH Month JULY Day 14 Year 19 57.			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 4, 1898	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dental Assistant				10b. KIND OF BUSINESS OR INDUSTRY Dentist's Office		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HENRY PAUPE				14. MOTHER'S MAIDEN NAME SOPHIA RITTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-16-6803		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (Dysplasia) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. breast removed 5-4-55							INTERVAL BETWEEN ONSET AND DEATH from 4-26-55
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-26-55 to 7-14-57 that I last saw the deceased alive on 7-14-57 and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Wm. F. Williams, Cumberland, Md. DATE SIGNED 7-15-57							
ACTUAL SIGNATURE Wm. F. Williams, M.D.							
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 17, 1957		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR July 17, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL		d. STREET ADDRESS P.O. BOX 155, WILLOWBROOK ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie First CAROLYN Middle H. Last PFEIFFER		4. DATE OF DEATH Month JULY Day 16 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 13, 1875
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 2 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NATHAN BRESSLER		14. MOTHER'S MAIDEN NAME HANNAH CLINGAR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia, Right (c) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 8 days 1 month 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , to July 16, 1957 , that I last saw the deceased alive on July 16, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 59 Greene St		DATE SIGNED 7/17/57	
ACTUAL SIGNATURE S G WEISMAN		M.D. Cumberland, Md	
PHYSICIAN'S NAME (Type) S G WEISMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1957	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24. REC'D BY REGISTRAR July 17, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, Md. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX MALE		3. AGE 45	
4. RACE WHITE		5. DATE OF BIRTH JULY 10, 1912		6. PLACE OF BIRTH BALTIMORE, MD	
7. OCCUPATION FARMER		8. MARITAL STATUS MARRIED		9. PLACE OF DEATH BALTIMORE, MD	
10. CAUSE OF DEATH HEART DISEASE		11. DATE OF DEATH JULY 18, 1957		12. PLACE OF DEATH BALTIMORE, MD	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF WITNESS J. H. HARRIS		15. SIGNATURE OF DECEASED J. H. HARRIS	

BUREAU V. S.

JUL 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07021

CERTIFICATE OF DEATH

06988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Near Oldtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Near Oldtown X O	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nr. Oldtown, Maryland		d. STREET ADDRESS Nr. Oldtown, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AGNES Middle PIPER Last		4. DATE OF DEATH Month July Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Lonaconing Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME GEORGE W. BEEMAN		14. MOTHER'S MAIDEN NAME JULIA GARLITZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lawrence Piper, Oldtown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage Cerebral 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 , 19 57 , to June 12 , 19 57 , that I last saw the deceased alive on 6-12-57 , 19 57 , and that death occurred at 2 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Paw Paw, W. Va. DATE SIGNED 6-13-57			
ACTUAL SIGNATURE J. I. Armstrong		M.D. Paw Paw, W. Va.	
PHYSICIAN'S NAME (Type) J. I. Armstrong			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 15, 1957	
22c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery		22d. LOCATION (City, town, or county) (State) Oldtown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR July 14, 1957		REGISTRAR'S SIGNATURE Fry Duckworth	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06989

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.			c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 54 Oak St.				d. STREET ADDRESS 1 54 Oak St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Elizabeth Reuschel				4. DATE OF DEATH July 4, 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 23, 1902	
9. AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Martin				14. MOTHER'S MAIDEN NAME Henritta Heinrich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Carl G. Reuschel Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Throat 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3/16/55 19____, to 7/4/57 19____, that I last saw the deceased alive on 7/3/57 19____, and that death occurred at 10:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Richard J. Williams M.D. Cumberland, Md. PHYSICIAN'S NAME (Type) Richard J. Williams Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-57		22c. NAME OF CEMETERY OR CREMATORY St. Luke Luth. Cem.		22d. LOCATION (City, town, or county) _____ (State) _____ Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 8, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957 6 701

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06990

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	c. LENGTH OF STAY IN 1b 66 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Violet Last Richardson		4. DATE OF DEATH Month July Day 29 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 24 1891
9. AGE (In years less birthday) yrs. 66		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) Frostburg Md
13. FATHER'S NAME Robert Hart		12. CITIZEN OF WHAT COUNTRY? USA.	
14. MOTHER'S MAIDEN NAME Teresa Conrad			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT Osborne C. Richardson, Frostburg, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.3		INTERVAL BETWEEN ONSET AND DEATH 1 yr - Indef.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 56 , to July 30 , 19 57 , that I last saw the deceased alive on July 30 , 19 57 , and that death occurred at 12:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John B. Davis, M.D. 2 Broadway			
PHYSICIAN'S NAME (Type) John B. Davis, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug 2 1957	Frostburg Memorial Park	Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE 8-1-57
		24b. REGISTRAR'S SIGNATURE Miss Nancy N. R...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08109

Reg. Dist. No.

07010

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b X2 Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at Miners Hospital		d. STREET ADDRESS 1 St. Marys Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Junior Last Robertson		4. DATE OF DEATH Month July Day 31 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-17-1931 b. AGE (In years last birthday) 25 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) car inspector		10b. KIND OF BUSINESS OR INDUSTRY B&O.R.Ry.	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Robertson		14. MOTHER'S MAIDEN NAME Mary Staup	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-26-7686	
17. INFORMANT (wife) Mrs. Joanne Robertson		Address Md. Lonaconing	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intrathoracic hemorrhage due to a crushed 823X DUE TO chest, also/fracture of right clavicle (short) duration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auto accident. DUE TO (c) Auto accident.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Excessive speed, lost control, hit 2 Tel poles, turned over.	
20c. TIME OF INJURY Month, Day, Year 2 - July 31 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt 36		20f. (City or town) Gilmore (County) Allegany (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 31-1957	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 8/2/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR 8-3-57		24b. REGISTRAR'S SIGNATURE M. Nancy X/R 22	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 7 1957

RECEIVED

DR. BALLIN 6990

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY 85 x - 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 110 KNOBLEY STREET	
3. NAME OF DECEASED (Type or print) First Middle Last ELMER JONAS ROYCE		4. DATE OF DEATH Month Day Year JULY 31 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 29, 1893
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.CO.	
11. BIRTHPLACE (State or foreign country) OKONOKO, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM H. ROYCE		14. MOTHER'S MAIDEN NAME ANNIE WHITAGRE Anna Whitacre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-09-7046	
17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 7-29 , 19 57 to 7-31 , 19 57 , that I last saw the deceased alive on 7-30 , 19 57 , and that death occurred at 12:10AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md. DATE SIGNED 7-31-57		
ACTUAL SIGNATURE Royce W. Ballin M.D.		
PHYSICIAN'S NAME (Type) DR. R. BALLIN		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/57	22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery
22d. LOCATION (City, town, or county) (State) Old Furnace Rd. nr. Ridgeley, W.Va.		
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Aug. 2, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. RUTH H. HILL

WEST VIRGINIA HOSPITAL

BALTIMORE

WILLIAM H. BOYCE

117 KNOX STREET

WILLIAM H. BOYCE

WILLIAM H. BOYCE

117 KNOX STREET

WILLIAM H. BOYCE

JUL 21

WILLIAM H. BOYCE

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WILLIAM H. BOYCE

WILLIAM H. BOYCE

BUREAU V. S.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 220 9-5-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

06992

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 720 N. Centre St.,		d. STREET ADDRESS 720 N. Centre St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LESSIE Middle VARNER Last SKIDMORE		4. DATE OF DEATH Month July Day 31 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Tucker Co., W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William G. Varner		14. MOTHER'S MAIDEN NAME Laura A. Nestor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Maxine Brotemarkle		Address 720 N. Centre St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis (Senile) 422.2 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. II (b) Varicella Infusio DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year 19 Hour a. p. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 27, 1957 to July 31, 1957 , that I last saw the deceased alive on July 31, 1957 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., DATE SIGNED 			
ACTUAL SIGNATURE L. B. Mathews		M.D. 49 Greene St.,	
PHYSICIAN'S NAME (Type) L. B. Mathews M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/2/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Aug 2, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

CERTIFICATE OF DEATH

1. NAME OF DECEASED ALBERT		2. SEX Male		3. AGE 30	
4. OCCUPATION Carpenter		5. PLACE OF BIRTH Maryland		6. DATE OF BIRTH 1900	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. DATE OF DEATH Aug 3, 1931		11. TIME OF DEATH 10:00 AM		12. SIGNATURE OF PHYSICIAN J. H. Smith	
13. SIGNATURE OF REGISTRAR J. H. Smith		14. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		15. SIGNATURE OF DECEASED Albert	

BUREAU V. S.

AUG 5 1931

RECEIVED

Within corporate limits

66992

CERTIFICATE OF DEATH

06993

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 349 Williams Street		d. STREET ADDRESS 349 Williams Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clifton Middle Joseph Last Smith		4. DATE OF DEATH Month July Day 23 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1898
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor	
11. BIRTHPLACE (State or foreign country) Wellersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Smith		14. MOTHER'S MAIDEN NAME Idabelle Kennell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 422.2	
17. INFORMANT Guy C. Smith, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) 6 mos		INTERVAL BETWEEN ONSET AND DEATH 4 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15, 1957 , to July 23, 1957 , that I last saw the deceased alive on July 23, 1957 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 236 W. 1st Cumberland, Md. 7/24/57	
PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-26-57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR July 26, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1880		BALTIMORE, MD		JUL 28 1957		BALTIMORE, MD		HEART DISEASE		NATURAL	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		OCCUPATION		HISTORY OF DISEASE		TREATMENT		POST-MORTEM		BURIAL	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		LABORER		HYPERTENSION		MEDICATION		NO		CATHOLIC	
JAMES H. HARRIS		JANE H. HARRIS		MARY H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		LABORER		HYPERTENSION		MEDICATION		NO		CATHOLIC	

BUREAU V. S.

JUL 29 1957

RECEIVED

Within corporate limits:

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06994

06993

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Alleghany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Alleghany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 30 Years		d. STREET ADDRESS 805. Washington Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 805. Washington St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eleanor Middle Stafford Last Stafford		4. DATE OF DEATH Month July Day 9 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1877
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House		10b. KIND OF BUSINESS OR INDUSTRY House Wife	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David P. Osborne		14. MOTHER'S MAIDEN NAME Frances Ramsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gail Ash		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Short time
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-17 , 19 57 , to 7-9 , 19 57 , that I last saw the deceased alive on 7-9 , 19 57 , and that death occurred at 5a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wm. F. Williams M.D.		ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland	
PHYSICIAN'S NAME (Type) Wm. F. Williams, M.D.		DATE SIGNED 7-9-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/10/1957	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight		ADDRESS Cumberland, Md	
24a. REG'D BY REGISTRAR July 10, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. 5

JUL 11 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06995

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL- MEMORIAL & WARWICK AVES.			e. STREET ADDRESS 1 628 N. CENTRE ST.,		
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last STAKEM			4. DATE OF DEATH Month JULY Day 27 Year 19 57.		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 27, 1957.		9. AGE (In years last birthday) yrs. 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland U. S. A.
13. FATHER'S NAME JOSEPH F. STAKEM			14. MOTHER'S MAIDEN NAME ROSE MARIE McMAHON McMahon		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Failure 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Univentricular Heart (Congenital) DUE TO (c) 30 min					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 27 July , 19 57 to 27 July , 19 57 , that I last saw the deceased alive on 27 July , 19 57 , and that death occurred at 5:22 P. M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE Leland B. Ransom			ADDRESS (Street, city or town, state) 63 Greene St., Cumberland, Md.		
PHYSICIAN'S NAME (Type) DR. LELAND B. RANSOM			DATE SIGNED 8/5/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-29-57	22c. NAME OF CEMETERY OR CREMATORY St Patrick Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			24a. REC'D BY REGISTRAR July 29, 1957		
ADDRESS Cumberland, Md.			24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Page One

PLACE OF DEATH ALLEGANY		PLACE OF BIRTH ALLEGANY	
SEX MALE		AGE 30 YEARS	
RACE WHITE		OCCUPATION ENGINEER & MECHANIC	
DATE OF DEATH JULY 27, 1957		TIME OF DEATH 10:00 AM	
PLACE OF DEATH ST. JOSEPH'S HOSPITAL		PLACE OF BIRTH ALLEGANY	
SEX MALE		AGE 30 YEARS	
RACE WHITE		OCCUPATION ENGINEER & MECHANIC	
DATE OF DEATH JULY 27, 1957		TIME OF DEATH 10:00 AM	
PLACE OF DEATH ST. JOSEPH'S HOSPITAL		PLACE OF BIRTH ALLEGANY	

BUREAU V. S.

JUL 30 1957

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 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
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 CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			c. LENGTH OF STAY IN 1b 70 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dudley Street				d. STREET ADDRESS Dudley Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle E. Last Steele				4. DATE OF DEATH Month July Day 4 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17, 1869	
9. AGE (In years lost birthday) 88 yrs.		10. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Durham, England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Steven Emerson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Jessie Neat		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Congestive Heart failure							INTERVAL BETWEEN ONSET AND DEATH 6 hours years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to July 4 , 19 57 , that I last saw the deceased alive on July 4 , 19 57 , and that death occurred at 10 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 7.5.57 ACTUAL SIGNATURE Jessie R. Miles M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. RECEIVED BY REGISTRAR DATE 7/6/57	
				24b. REGISTRAR'S SIGNATURE Joanette M. Boal			

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

OK ALL CERTIFICATES

7/11/57

10-1-57

George Johnson

10-1-57

10-1-57

10

none

Mrs. Anna West

10-1-57

Steven Johnson

10-1-57

House Work

Can Work

Durham, England

U.S.A.

Female

White

10-1-57

March 17, 1908

10-1-57

10-1-57

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CERTIFICATE OF DEATH

BUREAU V. S.

JUL 9 1957

RECEIVED

OK ALL CERTIFICATES

7/11/57

10-1-57

George Johnson

10-1-57

10-1-57

10

none

Mrs. Anna West

10-1-57

Steven Johnson

10-1-57

House Work

Can Work

Durham, England

U.S.A.

Female

White

10-1-57

March 17, 1908

10-1-57

10-1-57

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10-1-57

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1 154 Green Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Stevens Last Stevens				4. DATE OF DEATH Month July Day 9th Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6th, 1887	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min. 69			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Traffic Dept.				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Stevens				14. MOTHER'S MAIDEN NAME Sarah Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 1				16. SOCIAL SECURITY NO. 214-07-6456			
17. INFORMANT Mrs. Idella Stevens				Address 154 Green St., Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 Chronic Emphysema				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 55 , to July , 19 57 , that I last saw the deceased alive on July 7 , 19 57 , and that death occurred at 1 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Devers				ADDRESS (Street, city or town, state) 134 E. Main St., Frostburg, Md.			
PHYSICIAN'S NAME (Type) Dr. John C. Devers				DATE SIGNED 7-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 7-11-57	
24b. REGISTRAR'S SIGNATURE Mr. Nancy H. Re							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

JUL 15 1957

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06995

CERTIFICATE OF DEATH

06998

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 Baltimore Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ERNEST HUNTER TALA FERRO		4. DATE OF DEATH Month July Day 11 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Gordonsville, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Francis Taliaferro		14. MOTHER'S MAIDEN NAME Eliza Dickinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-03-3224	
17. INFORMANT 229 Baltimore Avenue		Address Jack Towler, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. — p. m. — 19 —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/17/53 , 19 — , to 7/11/57 , 19 — , that I last saw the deceased alive on 7/11/57 , 19 — , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 7/12/57			
ACTUAL SIGNATURE Richard J. Williams M.D.		PHYSICIAN'S NAME (Type) Richard J. Williams M.D., 122 South Centre Street, Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1957	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24. REC'D BY REGISTRAR July 13, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar			

07012

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
f. STREET ADDRESS 138 E. College Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Rushton Last Thomas				4. DATE OF DEATH Month July Day 18th , Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 4th, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min.		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph Rushton				14. MOTHER'S MAIDEN NAME Sarah Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 331X				16. SOCIAL SECURITY NO. 213-12-9760		17. INFORMANT Mrs. LaFern Schell, 112 Harrison St., Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO ypm (c) Hypertension						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 446X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1955 to July 18, 1957 , that I last saw the deceased alive on July 18, 1957 , and that death occurred at 10 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Devers				ADDRESS (Street, city or town, state) 134 E. Main St., Frostburg, Md.			
DATE SIGNED 7/18/57							
PHYSICIAN'S NAME (Type) Dr. John C. Devers,				134 E. Main St., Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-21-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 7-22-57	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy K. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

DECEASED NAME LAST FIRST MIDDLE THOMAS JAMES THOMAS		SEX MALE FEMALE	
AGE YEARS MONTHS DAYS 10 0 0		DATE OF BIRTH NOV. 10 1947	
PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF DEATH BALTIMORE, MARYLAND	
OCCUPATION STUDENT		CAUSE OF DEATH CONGENITAL HEART DISEASE (Specify)	
SIGNATURE OF DECEASED (If living)		SIGNATURE OF WITNESSES (If living)	
SIGNATURE OF PHYSICIAN (If living)		SIGNATURE OF CORONER (If living)	
SIGNATURE OF REGISTRAR (If living)		SIGNATURE OF CLERK (If living)	

BUREAU V. 2

JUL 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN Tb 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Calvin Middle Cooledge Last Thrasher				4. DATE OF DEATH Month July Day 31 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27-1924	
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest	
10b. KIND OF BUSINESS OR INDUSTRY Tack Fast Mfg. Co.		11. BIRTHPLACE (State or foreign country) Midland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John N. Thrasher	
14. MOTHER'S MAIDEN NAME Pansey Fazebaker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		16. SOCIAL SECURITY NO. 217-14-4807		17. INFORMANT Address (wife) Shirley Thrasher, Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-abdominal hemorrhage due to a crushed DUE TO (b) pelvis also fracture of right femur, lower DUE TO (c) ribs fractured right side of chest. Auto accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Passenger in auto, excessive speed, hit 2 telephone poles				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year 2 July 31 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway Rt 36		20f. (City or town) (County) (State) Gilmore Allegany Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 31-1957				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/57		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md			
24a. REC'D BY REGISTRAR 8-3-57		24b. REGISTRAR'S SIGNATURE J. H. [Signature]					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

6995

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 806 Shriver Ave		d. STREET ADDRESS 806 Shriver Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nora M. Middle Thuss Last Thuss		4. DATE OF DEATH Month July Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27-1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 4	IF UNDER 24 HRS. Hours 13 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Miller		14. MOTHER'S MAIDEN NAME Barbara Lapp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William T. Thuss, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 331X Cerebral hemorrhage (apoplexy) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 6 yrs DUE TO Generalized arteriosclerosis (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 15-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 16, 1957	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.		24a. REC'D BY REGISTRAR July 16, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES J. JONES		Male		45		White		July 17, 1957		Boston, Mass.	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF ATTENDING PHYSICIAN		12. SIGNATURE OF CORONER	
Salesman		Myocardial Infarction		Natural		[Signature]		[Signature]		[Signature]	
13. HISTORY OF PRESENT ILLNESS		14. MEDICAL HISTORY		15. SOCIAL HISTORY		16. FAMILY HISTORY		17. PATHOLOGICAL FINDINGS		18. OTHER FINDINGS	
Patient was well until July 10, 1957, when he began to experience chest pain and shortness of breath. He was taken to the hospital and died on July 17, 1957.		Hypertension, Diabetes Mellitus		No alcohol, no tobacco		None		Coronary atherosclerosis, Myocardial infarction		None	

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CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>229 Mary Street</u>		d. STREET ADDRESS <u>1 229 Mary Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Vernon</u> Last <u>Trout</u>		4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1887</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumb. Cont. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Trout</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Hildebrant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-9101</u>	
17. INFORMANT <u>Mrs. Eva Trout, 229 Mary Street</u>		Address <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure (about 1 hour)</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Unknown</u> <u>3 years</u> <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Winter</u> , 19 <u>56</u> , to <u>July 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>57</u> , and that death occurred at <u>7:00</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>59 GREENE ST</u> DATE SIGNED <u>7/7/57</u>			
ACTUAL SIGNATURE <u>Abraham Weisman</u>		M.D. <u>59 GREENE ST</u>	
PHYSICIAN'S NAME (Type) <u>J. G. WEISMAN MD</u>		<u>Cumberland Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Allegany County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24. REC'D BY REGISTRAR <u>July 7, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 1 Day		d. STREET ADDRESS 430 N. CENTRE ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY BOY Middle TWIGG Last TWIGG		4. DATE OF DEATH Month JULY 4, Day 19 Year 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3, 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. 1 Months 1 Days 1 Hours 1 Min.
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DONALD R. TWIGG		14. MOTHER'S MAIDEN NAME ELEANOR V. DU VALL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cyanosis 754.2 DUE TO Inter-ventricular Septal Defect - congenital Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Life (c) Defect - congenital			INTERVAL BETWEEN ONSET AND DEATH Life
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 3, 1957 to July 4, 1957 , that I last saw the deceased alive on July 4, 1957 , and that death occurred at 9:02 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Lusby M.D.		ADDRESS (Street, city or town, state) 121 BEDFORD ST CUMBERLAND, MD.	
PHYSICIAN'S NAME (Type) THOMAS F. LUSBY		DATE SIGNED 7/4/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 6, 1957	22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Meth. Cem.	22d. LOCATION (City, town, or county) (State) Spring Gap, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer,		24. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.	
ADDRESS 230 Baltimore Avenue Cumberland, Maryland		DATE July 6, 1957	

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM J. ALLEN		AGE 65		SEX MALE		RACE WHITE		DATE OF BIRTH 1890		PLACE OF BIRTH NEW YORK	
RESIDENCE 1000 N. CENTRAL ST.		OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		DATE OF DEATH JUL 8 1957		PLACE OF DEATH GENERAL HOSPITAL	
FATHER'S NAME WILLIAM J. ALLEN		MOTHER'S NAME MARY J. ALLEN		MARITAL STATUS MARRIED		EDUCATION HIGH SCHOOL		RELIGION CATHOLIC		SIGNED BY DR. J. H. SMITH	
DECEASED'S SIGNATURE <i>William J. Allen</i>		WITNESSES' SIGNATURES <i>John Doe, Jane Doe</i>		DECEASED'S ADDRESS 1000 N. CENTRAL ST.		WITNESSES' ADDRESSES 1000 N. CENTRAL ST.		DECEASED'S PHONE 1234		WITNESSES' PHONES 1234	
DECEASED'S SOCIAL SECURITY NUMBER 123-45-6789		DECEASED'S MARITAL STATUS MARRIED		DECEASED'S OCCUPATION CLERK		DECEASED'S EDUCATION HIGH SCHOOL		DECEASED'S RELIGION CATHOLIC		DECEASED'S RACE WHITE	
DECEASED'S DATE OF BIRTH 1890		DECEASED'S PLACE OF BIRTH NEW YORK		DECEASED'S DATE OF DEATH JUL 8 1957		DECEASED'S PLACE OF DEATH GENERAL HOSPITAL		DECEASED'S CAUSE OF DEATH HEART DISEASE		DECEASED'S MANNER OF DEATH NATURAL	

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JUL 9 1957

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BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sacred Heart Hospital</u>				STREET ADDRESS (If rural give location) <u>Sacred Heart Hospital, Decatur St.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Lenore</u> (Middle) <u>Catherine</u> (Last) <u>(Sister Leonide) Wagner</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 27 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 4, 1887</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NUN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Daughters of Charity</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jackson Wagner</u>				14. MOTHER'S MAIDEN NAME <u>Anna Yost</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sacred Heart Hospital</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						15 years	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-27</u> , 19 <u>57</u> , to <u>7-27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-27</u> , 19 <u>57</u> , and that death occurred at <u>9:15p</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Laura W. Bacon</u>				ADDRESS (Street, city, town, state) <u>M.D. 62 Greene St. Cumberland, Md.</u>		DATE SIGNED <u>7-28-57</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 29 1957</u>		NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>		LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>July 29, 1957</u>		REGISTRAR'S SIGNATURE <u>W. Ross Cameron, Md. Acting Registrar</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md.</u>	

CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

Decedent's Name

Sex

Age

Date of Birth

Date of Death

Place of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Burial Officer

Signature of Undertaker

Signature of Witness

Signature of Minister

Signature of Chaplain

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

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BUREAU V. 31

JUL 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> c7014 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN 1b <u>2 days</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u> d. STREET ADDRESS <u>18 Ormond St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>S.</u> Last <u>Weishaar</u>		4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2-1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Enginer at the</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Mount Airy, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Willis Weishaar</u>	
14. MOTHER'S MAIDEN NAME <u>Daisy Hood</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-01-6052</u>		17. INFORMANT Address <u>Miners Hospital records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> <u>816x</u> DUE TO <u>Fractured skull</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u>Auto accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>Driving east on Rt. 40, ran off road, on shoulder, attempt to get it back on road, lost control, hit an auto & he was thrown out.</u>	
20b. TIME OF INJURY Month, Day, Year <u>6.20</u> o. m. <u>July 16 1957</u>	20c. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route # 40</u>	20e. (City or town) (County) (State) <u>Clarysville, Allegany, Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 18-1957</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7-20-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>7-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Xanay N. Aa</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		35		M		W		JUL 6 1968		10:00 PM		MEMPHIS, TENN.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
MEMPHIS, TENN.		ATTORNEY		HIGH SCHOOL		MARRIED		HEART DISEASE		SUICIDE		JAMES EARL RAY	
DATE OF BIRTH		DATE OF DEATH		DATE OF MARRIAGE		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
JUL 6 1968		JUL 6 1968		JUL 6 1968		JUL 6 1968		JUL 6 1968		JUL 6 1968		JUL 6 1968	

RECEIVED
 JUL 24 1968
 BUREAU V. S.

07001

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>632 Washington St</u>				d. STREET ADDRESS <u>632 Washington St</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>F Brooke Whiting</u>				4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 18, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>		IF UNDER 24 HRS. Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Moorefield, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>James J. Whiting</u>				14. MOTHER'S MAIDEN NAME <u>Sidney C. Hutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Spanish Am.</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Ruth Whiting Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>Far advanced cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cholelithiasis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-13-1956</u> to <u>7-24-1957</u> that I last saw the deceased alive on <u>7-23-1957</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland Md.</u> DATE SIGNED <u>7-25-57</u>							
ACTUAL SIGNATURE <u>W. F. Williams</u> M.D.							
PHYSICIAN'S NAME (Type) <u>W. F. Williams, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 27 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Louis Stein Inc. Cumb. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>July 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, TO

BUREAU V. S.

JUL 29 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07007

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

07002

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>52 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>700 Gephart Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Samuel</u> Last <u>Wolfe</u>				4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25-1905</u>	
9. AGE (in years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interviewer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Employment Security</u>			
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Kinsey A. Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Jennie M. Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. 2</u>				16. SOCIAL SECURITY NO. <u>217-10-5529</u>			
17. INFORMANT <u>(brother) K. Albert Wolfe</u>				Address <u>Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>July 11-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>July 13, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

RECEIVED